

NOTATION VOTE

RESPONSE SHEET

TO: Annette Vietti-Cook, Secretary  
FROM: COMMISSIONER MCGAFFIGAN  
SUBJECT: **SECY-00-0003 - REPORT TO CONGRESS ON ABNORMAL OCCURRENCES FOR FISCAL YEAR 1999**

Approved  Disapproved \_\_\_\_\_ Abstain \_\_\_\_\_

Not Participating \_\_\_\_\_

COMMENTS:

*See attached edits. I also concur in Commissioner  
Messfield's comments.*

*Edward McGaffigan Jr.*  
\_\_\_\_\_  
SIGNATURE

*January 21, 2000*  
\_\_\_\_\_  
DATE

Entered on "AS" Yes  No \_\_\_\_\_

(1)

PARALLEL  
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pressure gas storage containers are typically placed with the long axis perpendicular to building walls and at a substantial standoff distance to minimize the possibility of wall penetration in the event of a catastrophic failure of a container.

In conclusion, this hydrogen fire did not threaten safe-shutdown equipment, nor did it cause an event that would require the use of safe-shutdown equipment. Further, the fire did not pose a threat to the health and safety of the public, the environment, or national security.

This event is closed for the purpose of this report.

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2. Scram and Partial Loss of Vital Power at Indian Point Unit 2

A scram at Indian Point Unit 2 on August 31, 1999, involved a number of complications and produced unnecessary burdens on the licensee's operational personnel. The event revealed lapses in configuration control and management oversight that caused NRC to increase its attention to the licensee's overall safety program and caused significant public and media interest.

At 2:31 p.m., the Indian Point Unit 2 reactor was automatically tripped from 99 percent power with the trip indication being an over temperature delta-temperature (OTΔT) signal. About 3 minutes after the reactor trip, the normal offsite power breakers to all four 480 volt (V) vital buses tripped; all three emergency diesel generators (EDGs) started and began to load. Almost immediately, the EDG 23 output breaker tripped, leaving the 6A vital bus de-energized. This resulted in a loss of power to one of the two motor-driven auxiliary feedwater pumps, to battery charger 24, and to some emergency core cooling components. The bus remained de-energized while technicians prepared tagouts and checked for a suspected bus fault, which could have caused the loss of power. Battery 24 discharged over the next 7 hours. After it was fully depleted, it caused a loss of power to the loads on the 24 direct current (dc) bus and on the 24 alternating current (ac) instrument bus. Because of the loss of the dc bus, half of the bleed and feed capability of the unit would not have functioned if it had been required and the emergency feedwater flow control process was complicated. The loss of the ac instrument bus disabled most of the control room annunciators for safety-related systems. The next day, about 1:00 a.m., vital bus 6A was re-energized using the EDG; by 9:00 p.m., normal off-site power had been restored to all buses and the three EDGs were secured.

The NRC sent an Augmented Inspection Team (AIT) to examine the circumstances surrounding the event, principally because the event was complicated by significant, unexpected system interactions involving safety-related equipment. The team was also instructed to examine the adequacy of the licensee's response to the event, particularly the vital bus power restoration efforts. The delay in restoration led to significant additional complication of the operators' efforts to stabilize the plant. The team's report is presented in Inspection Report 50-247/99-08, dated October 19, 1999.

The team found that a significant contributor to the event was inadequate configuration control. The loss of bus 6A and subsequent degradation of plant conditions were caused by two equipment configuration control problems: the station auxiliary transformer load tap changer had been left in the "manual" position and the overcurrent trip for EDG 23 output breaker was



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

WASHINGTON, D.C. 20555-0001

Identical changes should be  
made to the letter to  
Representative Hasterik.

The Honorable Albert J. Gore, Jr.  
President of the United States Senate  
Washington, D.C. 20510

Dear Mr. President:

I am forwarding our "Report to Congress on Abnormal Occurrences Fiscal Year 1999" for events at nuclear facilities. This report is required by Section 208 of the Energy Reorganization Act of 1974 (Public Law 93-438). In the context of the act, an abnormal occurrence (AO) is an unscheduled incident or event that the Commission determines to be significant from the standpoint of public health or safety. The Federal Reports Elimination and Sunset Act of 1995 (Public Law 104-66) requires that AOs be reported to Congress annually.

The report addresses four AOs at facilities licensed or otherwise regulated by NRC. One event involved a fire that breached containment and required shutdown of a portion of the cascade at ~~a~~ gaseous diffusion plant. Two medical events involved the administration of radioactive material to pregnant women and one event involved a sodium iodide misadministration. The report also addresses nine AOs at facilities licensed by Agreement States. Agreement States are those States that have entered into a formal agreement with NRC pursuant to Section 274 of the Atomic Energy Act (AEA) to regulate certain quantities of AEA material at facilities located within their borders. Currently, there are 31 Agreement States. One of the Agreement State AOs involved the administration of radioactive material to a pregnant woman, two involved overexposures of an occupational worker and a member of the public at industrial radiography operations, two involved gamma stereotactic radiosurgery misadministrations, three involved therapeutic radiopharmaceutical misadministrations, and one involved sodium iodide misadministration.

Sincerely,

Richard A. Meserve

Enclosure: "Report to Congress on Abnormal  
Occurrences Fiscal Year 1999"